# Senate

General Assembly

**File No. 195**

***January Session, 2009***

Senate Bill No. 988

*Senate, March 25, 2009*

The Committee on Human Services reported through SEN. DOYLE of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

***AN ACT CONCERNING MEDICAID FUNDING FOR SAGA AND CHARTER OAK.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) Not later than January 1, 2010, the Commissioner of Social Services shall apply for a waiver of federal law under the Health Insurance Flexibility and Accountability demonstration initiative for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under (1) the state-administered general assistance program, and (2) the Charter Oak Health Plan, established pursuant to section 17b-311 of the general statutes. The commissioner shall submit the application for the waiver to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations prior to submitting the application to the federal government in accordance with section 17b-8 of the general statutes.

(b) If the commissioner fails to submit the application for the waiver to the joint standing committees of the General Assembly having

cognizance of matters relating to human services and appropriations by January 1, 2010, the commissioner shall submit a written report to said committees not later than January 2, 2010. The report shall include, but not be limited to: (1) An explanation of the reasons for failing to seek the waiver; and (2) an estimate of the cost savings that would result from the approval of the waiver in one calendar year.

Sec. 2. Section 17b-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

(b) Each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine

appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance from a federally qualified health center. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. Each person eligible for state-administered general assistance shall be entitled to receive hospital services. Medical services under the program shall be limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. Ancillary or specialty services provided under the program shall not exceed such services provided under the state-administered general assistance program on July 1, 2003, except for nonemergency medical transportation and vision care services which may be provided on a limited basis within available appropriations. Notwithstanding any provision of this subsection, the commissioner may, when determined cost effective, provide or require a contractor to provide home health services or skilled nursing facility coverage for state-administered general assistance recipients being discharged from a chronic disease hospital.

(c) Pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified

health center that does not have a contract for pharmacy services shall receive pharmacy services at pharmacies designated by the commissioner. The Commissioner of Social Services or the managed care organization or other entity performing administrative functions for the program as permitted in subsection (d) of this section, shall require prior authorization for coverage of drugs for the treatment of erectile dysfunction. The commissioner or the managed care organization or other entity performing administrative functions for the program may limit or exclude coverage for drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969.

(d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The commissioner shall, within available appropriations, make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions, including a grievance process for recipients to access review of a denial of coverage for a specific medical service, and to operate the program in whole or in part. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies. A recipient who has exhausted the grievance process established through such contract and wishes to seek further review of the denial of coverage for a specific medical service may request a hearing in accordance with the provisions of section 17b-60.

(e) Each federally qualified health center participating in the program shall enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.

(f) The Commissioner of Social Services shall, within available appropriations, make payments to hospitals for inpatient services based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments for any ancillary or specialty services provided to state-administered general assistance recipients under this section based on a methodology determined by the commissioner.

**[**(g) On or before January 1, 2008, the Commissioner of Social Services shall seek a waiver of federal law for the purpose of extending health insurance coverage under Medicaid to persons with income not in excess of one hundred per cent of the federal poverty level who otherwise qualify for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply to this section.**]**

**[**(h)**]** (g) The commissioner, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *from passage* | New section |

| | | |
|---|---|---|
| Sec. 2 | *from passage* | 17b-192 |

***HS*** *Joint Favorable*

## *OFA Fiscal Note*

### *State Impact:*

| Agency Affected | Fund-Effect |
|---|---|
| Department of Social Services | GF - See Below |

***Municipal Impact:*** None

### *Explanation*

This bill requires the Department of Social Services to enroll State Administered General Assistance (SAGA) and Charter Oak Health Plan clients in Medicaid via a federal Health Insurance Flexibility and Accountability (HIFA) waiver. The bill also repeals a section of statute that previously required SAGA to be expanded and included in Medicaid. This section was never implemented, and therefore has no fiscal impact.

Currently, the state only receives federal reimbursement (via the Disproportionate Share Hospital grant) for the hospital inpatient and outpatient portions of the SAGA program. The following table illustrates the FY 10 current services estimated costs for SAGA:

| | FY10 |
|---|---|
| Hospital Payments | $ 61,322,400 |
| Other Medical Payments | $ 121,393,055 |
| GA Managed Care (DMHAS) | $ 83,281,389 |
| **TOTAL** | **$ 265,996,844** |
| Fed Revenue - DSS | $ (30,661,200) |
| Fed Revenue - DMHAS | $ (7,495,325) |
| **Net State Program Costs** | **$ 227,840,319** |

As indicated by the table, there are approximately $190 million in

non-hospital SAGA costs (including behavioral health care) that are not currently eligible for federal reimbursement. The state receives no federal reimbursement for Charter Oak expenditures, estimated in FY 10 to be $20.8 million.

It cannot be anticipated what the structure of the HIFA waiver submitted by the department will be, nor what the federal government may require prior to final approval of federal financial participation. (For the purposes of this analysis, it is assumed that any such waiver is specific only to the SAGA and Charter Oak programs, and does not alter the structure of the current state Medicaid program.)

HIFA waivers allow states great flexibility in structuring benefits. Both the SAGA and Charter Oak program have substantially different benefit plans and payment mechanisms as compared to the Medicaid program. Should the federal government simply allow these program structures to be maintained while providing federal reimbursement (which is unlikely), the state would realize a net revenue gain of $95 million.

It is more likely that the federal government would require substantial changes in these programs prior to waiver approval. These changes would likely increase the overall cost of the program, thereby reducing the net state gain. Although the changes required cannot be anticipated, the state would likely see a net gain even with substantial increases (up to 70%) in the overall programmatic costs.

DSS will also incur additional administrative costs (likely between $100,000 and $200,000) for staff and contractual obligations necessary to develop and submit such a waiver

### *The Out Years*

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

*Sources: DSS cost and caseload data, current services budget estimates, OLR bill summary, public hearing testimony.*

**OLR Bill Analysis**

**SB 988**

***AN ACT CONCERNING MEDICAID FUNDING FOR SAGA AND CHARTER OAK.***

## SUMMARY:

This bill requires the Department of Social Services (DSS) commissioner, by January 1, 2010, to apply for a federal Health Insurance and Flexibility and Accountability (HIFA) demonstration waiver to provide Medicaid coverage to individuals qualifying for either the State-Administered General Assistance (SAGA) medical assistance program or the Charter Oak Health Plan (see BACKGROUND). Currently, state funds are used to pay for the SAGA program and the subsidized portion of the Charter Oak Health Plan. Medicaid coverage would provide a 50% federal match for these state expenditures.

The bill requires the commissioner to submit the application to the Human Services and Appropriations committees before sending it to the federal Medicaid agency, in accordance with state law. If he fails to do so by the above date, he must submit a written report to both committees explaining (1) why he has not done so and (2) an estimate of the cost savings that such a waiver would provide in a single calendar year. This report must be submitted by January 2, 2010.

Under current law, the DSS commissioner, by January 1, 2008, was to have sought a waiver to cover SAGA recipients with income up to 100% of the federal poverty level. He never sought the waiver. The bill repeals this separate provision.

EFFECTIVE DATE: Upon passage

## BACKGROUND

### *Federal Waivers*

Federal Medicaid law (Section 1115 of the Social Security Act) allows states to request "demonstration" waivers of federal rules to expand health care coverage when those rules would otherwise not allow such, or to limit whom the program covers. These waivers are generally good for five years but can be renewed.

The federal government introduced the HIFA waiver in 2001, which used the existing 1115 Medicaid waiver to encourage states, through their Medicaid- and State Children's Health Insurance Program-funded programs, to experiment with alternate strategies in an effort to reduce the number of uninsured residents. The federal Medicaid agency gave states broad authority under these waivers, including limiting enrollment, modifying benefit structures, and increasing beneficiaries' cost sharing which, without the waiver, would not be allowed. At the same time, states were expected to expand coverage.

States may still request 1115 waivers, which are research and demonstration waivers that allow states to experiment with coverage. These states must be able to demonstrate that they are "budget neutral" over the life of the demonstration, meaning they cannot be expected to cost the federal government more than it would cost without the waiver.

### *Legislative Approval of Waivers—CGS §17b-8*

State law requires the DSS commissioner, when submitting an application for a federal waiver for anything more than routine operational issues, to submit the waiver to the Human Services and Appropriations committees before sending it to the federal government. The committees have 30 days to hold a hearing and advise the commissioner of their approval, denial, or modification to it. If the committees deny the application, the commissioner may not submit it to the federal government. The law also sets up a process for when the committees do not agree. If the committees do not act within the 30 day period, the application is deemed approved.

### *Medicaid Coverage for SAGA*

In 2003, the legislature directed DSS to seek a Medicaid waiver to cover SAGA medical assistance recipients by March 1, 2004 (PA 03-3, June 30 SS). In 2007, the legislature extended the deadline from March 1, 2004 until January 1, 2008 and extended it to individuals with incomes up to 100% of the FPL (PA 07-185). Currently, SAGA medical assistance is available to individuals with income up to about 55% of the FPL.

### *Charter Oak Health Plan*

Since August 2008, the Charter Oak Health Plan has offered state residents another health insurance option. Individuals must be uninsured for at least six months to qualify and benefits are provided by managed care organizations. The state provides both premium and deductible assistance to individuals whose incomes are under 300% of the federal poverty level.

### *Related Bills*

SHB 6402, favorably reported by the Human Services Committee, requires DSS to seek a HIFA waiver for SAGA and Charter Oak by January 1, 2010. SHB 6417, favorably reported by the Human Services Committee, requires DSS, by January 1, 2010, to seek a federal waiver to cover SAGA recipients.

## COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 12 Nay 6 (03/10/2009)